IHS Integrated Diabetes Education Recognition Program
Sample Program Description

Albuquerque Service Unit Diabetes Program and Education Program Description

The Albuquerque Service Unit (ASU) Diabetes Program is one of twenty Indian Health Service Model Diabetes Programs. It has provided clinical and educational services to Native American patients and their families since 1979. There are currently 1534 patients on the Service Unit diabetes registry and 929 of those are on the Albuquerque Indian Hospital diabetes registry. In the data collection year of 6/1/99 = 5/31/00 there were 71 newly diagnosed patients at the Albuquerque Indian Hospital clinic.

Diabetes Program Setting and Staff

The ASU Diabetes Program provides clinical and educational services at seven sites:

- Albuquerque Indian Hospital
- Alamo Navajo Reservation
- Isleta Pueblo
- Jemez Pueblo
- Sandia Pueblo
- Santa Ana Pueblo
- Zia Pueblo

Services also include community interventions. The multidisciplinary staff includes three certified diabetes educators, two part-time physicians, one physician assistant and support staff.

Diabetes Program Services

- Diabetes Clinics

Clinical services at seven sites provide comprehensive care to people with diabetes. This includes diabetes treatment and prevention of kidney disease, eye disease, heart disease, stroke, amputations and cancer. Prenatal care and diabetes prevention care are also provided. Diabetes and nutrition education and foot care provided at all clinics.

- Community Services

The ASU Diabetes Program partners with communities, including tribal grant programs, to develop health interventions. This includes consultations, technical assistance and direct education services such as health fairs, diabetes screenings, cooking classes and support groups.

- Diabetes Education

Educational materials, curriculum and programs are developed and tested by the program staff. These include a curriculum for newly diagnosed patients, a weight management class and a newsletter on diabetes and general health for ASU Diabetes Program patients. The curriculum for newly diagnosed patients is implemented at the Albuquerque Indian Hospital clinic only. It is our

intention to implement it in the future at the Field Clinics, but there is not adequate staffing to do so now.

- Professional Education

The ASU Diabetes Program provides education for medical staff, community health representatives, tribal health staff, nurses and other health care providers. This is done through formal trainings, mentoring and preceptorships. Training is provided for ASU, the IHS Albuquerque Area and at other sites nationally.

Diabetes Education Program for Newly Diagnosed Patients

Although education is available to all patients, our focus is on newly diagnoses patients. Newly diagnosed patients are defined as people who have been diagnoses with type 2 diabetes within the last 2 years and have not had any previous diabetes education.

The initial medical and educational assessment of the patient is done by the nurse educator or by the dietician. One-to-one counseling is scheduled at regular intervals, with a minimum of 6 appointments over a 5-6 month period. Instructional methods include discussion and demonstration. Culturally appropriate materials are utilized; many are ones developed by IHS Headquarters Diabetes Program or by our program.

Patients enter the program by physician or other health care provider (FNP, PA, or RN) referral. The initial assessment is made and he program is explained to the patient; follow-up appointments are scheduled. Families are encouraged to accompany patients. At each session the educator assists the patient in setting behavioral goals. At the completion of the program, follow-up appointments are scheduled; some follow-up may be done by telephone or at a home visit.

Unique features of the education program include:

- Education materials and methods are appropriate for the Native American population
- Newsletters are sent to patients 2-3 times a year
- Education programs (diabetes and general health promotion topics) are offered to outlying communities

The Education Program is under the administration of the Albuquerque Service Unit. The Education Program Coordinator reports to the Director of the Service Unit Diabetes Program. The Diabetes Program Director reports to the Service Unit Director. Diabetes Program staff communicates with the Service Unit Clinical Director, IHS Headquarters Diabetes Program and the IHS Albuquerque Area Diabetes Consultant (see Organizational Chart).

6/00

Source: Albuquerque Service Unit Diabetes Program

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The Diabetes Center of Excellence provides outpatient education and counseling services to American Indians/Alaska Natives served by the Phoenix Service Unit. Phoenix Service Unit has a diabetes registry of about 5300 active users. There are an average of 84 new people with diabetes added to the registry each month. Of these, approximately 30 are newly diagnosed with diabetes.

The Diabetes Center of Excellence offers a wide range of diabetes education and diabetes-related services including:
*Comprehensive diabetes self-care education for adults, DEPTH-Diabetes Education Path to Health, provided individually or in a group, to learn skills to control blood sugar and prevent/manage complications. This service is strongly recommended at diagnosis and whenever people with diabetes prefer to enhance their ability to manage diabetes.
*Counseling to assist patients to improve/maintain their blood sugar control and/or diabetes management capabilities as frequently as needed/requested. Sessions include adaptation to changes in work schedule, health status, exercise, medications, nutrition, lifestyle, economics and etc.
*Instruction to teach/review self-care skills such as self-blood glucose monitoring, insulin administration, foot care, etc.
*Counseling to review progress and provide assistance in achieving standards of care for diabetes management, such as eye, dental, neuro foot exams, immunizations, labs, etc.
*Counseling for pre-pregnancy diabetes management goals and their implementation to assist women to plan for pregnancy.
*Counseling for prenatal diabetes education to learn diabetes management skills during pregnancy.
*Counseling for assistance with weight loss and exercise for those who need extra support and encouragement.
*Case management for adults with diabetes.
*Support and encouragement with any aspect of diabetes care whenever needed.

Consumers are considered participants of the DEPTH Program if they specifically enroll to complete this curriculum in a group or individual setting. Participants enter the DEPTH Program through referral from any source. Most referrals are received from outpatient clinic primary care providers. See attached patient Referral Notice IHS-199-1, Revised 12/1/01 for diabetes education and DEPTH.

Once referred, the participant meets with an educator to develop their individual education plan. Adults with type 2 diabetes may choose to attend a 7-hour group class offered nine times a year. If classroom education is not desired, convenient, and/or appropriate to the individuals' learning needs, individual instruction will be provided. Participants may complete a combination of group and individual instruction if they choose.

Group instruction, for adults with type 2 diabetes is provided by a diabetes nurse educator and a dietitian. A pharmacist, physician, health educator, dental hygienist, foot care specialist and eye care specialist may serve as guest lectures. All group participants, meet individually with an educator to demonstrate skills, such as self-blood glucose monitoring, insulin administration and pre-conceptual counseling if childbearing potential. All participants meet individually with a dietitian to develop an

individualized meal plan. If individual instruction is chosen, education is provided by a nurse educator and the dietitian.

On completion of the instruction, the participants are reassessed to determine whether they have met the educational objectives. Additional individual instruction is provided until objectives are met. When the participant has met all learner objectives, he/she selects, with the assistance of an educator, one or more behavioral goals. All program participants have a follow-up appointment three to six months after completion of the program to assess their progress with behavior change goals and diabetes self care. The Diabetes Center of Excellence staff continues to see participants in regular follow-up and/or as requested by the participant.

Source: Phoenix Indian Medical Center (PIMC) DEPTH Program